HHS/CDC Global AIDS Program (GAP) in Namibia – FY 2003

About the Country of Namibia

Capital City: Windhoek
Area: 825,418 sq km
Population: 1.8 million

The HIV/AIDS Situation in Namibia

HIV Infected: 230,000[1]
AIDS Deaths: 13,000[2]
AIDS Orphans: 47,000[3]

Namibia is one of only seven countries in the world with HIV prevalence among adults in excess of 20%. (UNAIDS). The first AIDS cases were reported in 1986. Data compiled by the Ministry of Health and Social Services (MOHSS) show that AIDS became the leading cause of death in Namibia in 1996. In 1999, the reported number of 2,823 AIDS-related deaths accounted for 26% of all deaths and 47% of deaths in people between the ages of 15 and 49. The number of reported HIV/AIDS-related hospitalizations increased from 355 in 1993 to 7,746 in 2001 (MOHSS). As of 2002, approximately 230,000 Namibians are estimated to be living with HIV infection. Based on 75,000 births annually, 22% HIV prevalence, and a 40% transmission rate, approximately 6,700 infants are infected by HIV each year through mother-to-child-transmission. Currently estimated at 83,000, it is predicted that Namibia will have 118,000 AIDS orphans by 2006. The HIV epidemic in Namibia is predominantly due to heterosexual and mother-to-child transmission. Mobility, alcohol, urbanization, economic factors, low condom use, and cultural practices are considered to be important factors contributing to the heterosexual epidemic.

About the Global AIDS Program in Namibia

Year Established: 2002
FY 2003 Budget: $1.6 million USD
In-Country Staffing: 2 CDC Direct Hires; 6 Locally Employed Staff; 2 Contractors[4]

Program Activities and Accomplishments

In FY 2003, GAP Namibia achieved the following accomplishments in the highlighted areas:

HIV Prevention

- Revised the voluntary counseling and testing (VCT) curriculum for Namibia. An information system was established in the first of five freestanding non-governmental organization (NGO) "New Start" VCT centers franchised by Population Services International (PSI) to Catholic AIDS Action (CAA), Council of Churches of Namibia (CCN), local government, and the Red Cross.

[1] Figure represents a 2001 estimate taken from unpublished data in the GAP M&E Annual Report.
[2] Figure represents a 2001 estimate taken from the CIA World Fact Book, http://cia.gov/cia/publications/factbook/
[3] Figure represents a 2001 estimate taken from unpublished data in the GAP M&E Annual Report.
[4] Figure represents a May 2004 census taken by GAP staff; staffing subject to change.

- Tested 3,037 clients at “New Start” VCT Centers. Operation costs for these centers have come from European Union funding.

Preventing Mother-to-Child HIV Transmission (PMTCT)

- Expanded PMTCT services from two pilot sites to four other MOHSS hospitals.
- Drafted PMTCT Training of Trainers (TOT) curriculum for an 8-day course.
- Included the use of antiretroviral (ARV) drugs for PMTCT in seven ARV Therapy (ART) trainings for 232 health workers.

Care and Treatment

- Conducted a consensus-building meeting to provide initial guidance to six ART regions on how best to set up ART services.
- Began implementation of ART in five hospitals in six ART regions; the first 157 government patients were started on ART from August-September 2003.

Surveillance and Infrastructure Development

- Completed sentinel surveillance survey (2002). Data was analyzed and the report written.
- Purchased and installed CD4 laboratory equipment in the Namibia Institute of Pathology in Oshakati, allowing CD4 tests in the north for the first time.
- Developed task analysis and learning objectives for eight MOHSS training curricula: Tuberculosis, Sexually Transmitted Infections, PMTCT, VCT, ART, Case Management, Home-based Care, Orphans and Vulnerable Children.
- Supported the Namibia Institute of Pathology in developing a training curriculum for rapid HIV test training.
- Conducted seven ART trainings, reaching 232 health workers in 6 ART regions.
- Trained 37 counselors from MOHSS, the Social Marketing Association (SMA), CAA, and CCN using VCT curriculum.

Challenges

- VCT services are in urgent need of expansion in health facilities, beginning with the hospitals.
- The uptake of PMTCT during the pilot phase was low due to the highly voluntary nature of testing, lack of counselors, stigma, and lack of ART. Staffing increases and a more aggressive stance on testing will be needed to encourage more women to access PMTCT services.
- MOHSS does not plan to provide infant formula to HIV-positive mothers because of the high cost and concerns over sustainability. Many mothers cannot afford to purchase formula on their own. This may negate some of the gains from prenatal ART interventions.
- There is a major shortage of nurse-midwives (800 vacancies) and counselors in the health system. The counselor cadre has not been formally established, and the MOHSS depends on already overworked nurses to do all the counseling. To increase uptake of PMTCT, the use of lay counselors must be accepted by MOHSS management, trained, and deployed within a short timeframe.
- The government lacks adequate funding to train sufficient numbers of health care workers. Doctors, pharmacists, and laboratory technicians must be trained outside of the country. Nurses are trained in-country but it will take six to eight years to compensate for anticipated vacancies next year as a result of attrition (migration, HIV/AIDS) and the addition of new posts.